

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 10 1942

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 371

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community as above

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

(c) City or town North Kansas City,
(If outside city or town limits, write "RURAL")

(d) Street No. R. F. D. #8,
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Beauford Boyd Altic

3. (b) If veteran, name war no. 3. (c) Social Security No. 495-10-7422

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Doris Altic 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased October 12 1902
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>3</u>	<u>10</u>	hr. min.

9. Birthplace Illinois,
(City, town, or county) (State or foreign country)

10. Usual occupation Plumbing Supplies

11. Industry or business X

12. Name James Robert Altic,

13. Birthplace Illinois,
(City, town, or county) (State or foreign country)

14. Maiden name LU ETIA Dyer,
(City, town, or county) (State or foreign country)

15. Birthplace Illinois,
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Doris Altic,

(b) Address North Kansas City, Mo.

17. (a) Burial (b) Date thereof 1-25-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Scott Valley Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 1-25-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 22nd
year 1943 hour 8:05 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 1942
to Jan 22 1943
that I last saw him alive on Jan 22 - 1943 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Uremia Duration 3d

Due to Chronic Glomerulonephritis - 1 yr.

Due to 12/18

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F. Chawar (M. D. or other)

Address 324 1/2 W. 13th St. Date signed Jan 25 43

Dr. Lamar

940-3

Church St.

830

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 1445

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.